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The Motherhouse and Novitiate are located in Fox Chase, Philadelphia, Pa. There is also a House of Studies in Brookland, Washington, D.C., and Houses of Postulate in England and Holland.

The main activities of the Society include the conducting of hospitals, dispensaries, maternity and child welfare centers, training schools for native nurses and midwives, and similar health works.

Medical Mission Centers conducted by the Society in India and the United States are:

Holy Family Hospital, Rawalpindi, India
Holy Family Hospital, Patna, India
Mitford Muncipal Hospital, Dacca, Bengal, India
The Santa Fe Catholic Maternity Inst., Santa Fe, N.M.
The Catholic Colored Clinic, Atlanta, Georgia.

It is the purpose of the Society to send Medical Missionaries to any mission field of the world. The Society has many requests; it needs many vocations.

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ACROSS THE PAGES . . .

IN INDIA the ambulances are not the high-speeding, siren-hooting cars we have here—but they bring the patients just the same. Sister M. Elise Wijnen, M.D. tells how it's done.

DO YOU WONDER, sometimes, just what makes a missioner a missioner? "Will You Take It?" Will give you some of the answers.

IT'S EASY TO ASK—"How are you?" But getting the answer is another story. Sister M. Leonie Tummers, M.D., explains . . .

"NURSING OVER THE WORLD" is a bird's-eye view of the nursing situation in the United States, Latin-America, and parts of the Orient—by Sister M. Francis.

YOUR WILL . . . . .

can help the Medical Mission Sisters bring health and healing to the sick and suffering of mission lands. The following approved form of bequest may be used:

"I hereby give (devise) and bequeath to the Society of Catholic Medical Missionaries (also known as the Medical Mission Sisters), an institution incorporated under the laws of the State of Maryland, and its successors forever the sum of $..... for its general purposes."

Vocation

For nigh onto twenty centuries, in every generation, thousands of men and women, from among the best, in order to follow the counsels of Christ, have freely renounced the possibility of a family of their own and the sacred duties and rights of married life.

Is the common good of the people and the Church perhaps jeopardized by this? On the contrary, these generous souls recognize the union of the two sexes in matrimony as a good of high order. But if they abandon the ordinary way and leave the beaten track, they do not desert it, but rather consecrate themselves to the service of mankind with a complete disregard for themselves and their own interests by an act incomparably broader in its scope, more all-embracing and universal.

Look at those men and women: see them dedicated to prayer and penance, intent on the instruction and education of the young and ignorant, leaning over the pillow of the sick and dying, open-hearted for all their miseries, and all their weaknesses in order to relieve them, ease them, lighten them and sanctify them.

When one thinks of young girls and women who willingly renounce matrimony in order to consecrate themselves to a higher life of contemplation, sacrifice and charity, there comes at once to the lips the word that explains it: vocation. *It is the only word that can describe so lofty a sentiment.*

—Pope Pius XII

Ambulance

By Sister M. Elise Wijnen, S.C.M.M., M.D.

A basket hung on a pole—variously called a doolie, palki or dandi—and the oxcart are the usual ambulances of India.

City dwellers the world over are familiar with the insistent bell clanging or siren hooting, the hasty stepping aside of pedestrians and pulling up of cars that heralds the coming of the ambulance. Common courtesy readily accepts its need for the right of way, even though only a small percentage of the patients conveyed in ambulances are emergencies. But the well-known long car with its barely visible prostrate occupant requires no excuse.

In India the ambulances are much less spectacular. Some of the larger cities boast a few specially designed cars, but the average patient who is too sick to sit up in a rickshaw or tonga is brought to the hospital in a humbler manner. This conveyance varies with the locality and the wealth of the family, but basically it is nothing but a basket on a pole. It is variously called a *doolie* or a *palki,* or in some places a *dandi.* Some are pretentious affairs, resembling a huge wooden sewing box, with sliding doors and slits in the sides, like miniature Venetian blinds. They are furnished with blankets and pillows and may be of fairly good size. The lack of fresh air, the cramped position and the swaying motion as the doolie is carried along, do not seem to bother the Indian women at all. Some actually prefer the doolie to the rickshaw, because it is more purdah.

Most of the doolies, however, are miserably small and uncomfortable. They are barely the size of an armchair, made of a wooden frame and a string or cane seat and covered on all sides by a cloth which is hung from the central pole, thus forming a little tent. Often two women and a baby will emerge from such a contraption. Just to get a sick patient out is like extracting an old cork from a recalcitrant bottle! You feel as if at any moment you might lose some of the patient. Here a leg gets caught, there a sari catches on the corner, now a foot doubles over—oops, there goes a pillow! Experience teaches you that the best way to extract these sick and helpless women is backwards; you place your two hands under the patient's armpits and pull! With a little help and guidance from an assistant it can be done. How the patient is put inside these ambulances in the first place will forever remain a mystery.

The doolies are carried by coolies. (The alliteration is accidental!) These carriers take a great interest in their patient, much like the seasoned ambulance driver at home, who knows a good deal more than the brand-new intern, riding the "bus" for the first time. Often the coolies will relate the patient's history, describe the distance they have come, inform us as to the wealth of the family that hired him, all right in the middle of the compound.

The best rural ambulance yet devised in India is the oxcart. It can be rigged up like the old covered wagon and allows for a fair amount of fresh air. The slow pace of the oxen is less disturbing to the patient too. These carts come ten or fifteen miles from the *dehat* (country) and as long as the case is not an emergency, they do very well. Even when speed is essential, they just have to do, for there is nothing else available in most places. Very often these carts take four or five hours to make the journey. To get the patient out, you just lift the entire bedding and drag it onto the stretcher with the patient inside it, wrapped up like a cocoon.

All sorts and types of patients emerge from these ambulances. Many of them are delivery cases, and then the best thing to do is to have the doolie carried right into the operating room, put the coolies out, and lift the woman straight from the stretcher to the table. Those who arrive in doolies are bound to be in the last stage. Often a patient is *in extremis,* for a trip to the hospital is the very last thing a village woman will allow. After she has exhausted all her strength and her husband's goods to enrich the local quacks, after the next harvest has been extorted by the money lenders and the last goat sacrificed to the gods, only then will she start thinking about going to the hospital. Such is the reputation of bona fide medical care in India!

Sometimes it happens that we are fooled, and the patient inside the doolie is hardly sick at all. She is a very young, just married, highly purdah,

A well-covered tonga brings a patient to Holy Family Hospital in Patna.

village girl, as the coolies will soon tell you. Better drop the curtain and wait for the husband and mother-in-law to catch up and produce her themselves. Such a patient's troubles can wait safely enough.

Besides fear and distrust, there are many other circumstances which make Indian women hesitate to come to hospitals. Often I have seen patients in their homes, where it was all I could do to climb the narrow, winding, crumbling stairs to the loft where the patient had hid herself, far away from all fresh air and cheering sunshine. When I gave the verdict, "This woman should come to the hospital," I had to close my eyes to the rickety staircase, the muddy, rutted lanes and the many discomforts that lie between the patient's charpoy and the hospital bed. Yet, the family's objections are more likely to be: "The children will cry—there is no extra woman available to look after the house"—or "It is too far to carry the food twice a day," etc. Naturally such a profound disturbance in the household routine, such a radical change in habits and customs, is not to be taken lightly.

Knowing all this, you really have to admire the courage, the faith and the endurance of these "dooli-wallas." Shaking and tossing in their walking prisons, trembling with fever and exhaustion, stiff with fear of the unknown, they emerge from their familiar surroundings and entrust themselves to our mercy. Often the only reason for this action of theirs is the knowledge that someone of their acquaintance has recovered in this hospital. It is always a joy to us to see such a sick and fearful bundle of misery develop into a smiling and trustful convalescent. We know that each successful village case is the nucleus for an unlimited series of new patients from the same locality. No wonder, then, that at the sight of an "ambulance" we drop everything and rush to the rescue!

Wooden frame, string or cane stretcher and drapery hung from a central pole form the tentlike doolie or palki.

Will You Take It?

Looking at the Medical Mission Vocation . . .

Many a time, in the past three or four years, American soldiers and Army nurses have called on us, here at Holy Family Hospital, usually in the middle of a busy morning or afternoon. After they had seen the place, a little bit of India in the raw, sooner or later the inevitable question would crop up, "How long have you been here, Sister?" And when they received their answer, five or ten or fifteen years, as the case may be, they would whistle in amazement and say: "How in the world do you stick it, Sister? Why we can't get away fast enough!" They were aching to get home again, poor fellows, and we could understand it so easily. Yet for us, one of the greatest crosses imaginable would be—a one-way ticket home!

Sometimes we would discuss it among ourselves and cogitate over it. For it *is* a strange thing, when you think of it. Certainly India is no more kind or attractive to us than it is to them. No doubt we see a great deal more of it than the G.I.'s, who all but brought America with them when they came. Nor do we forget or despise the comforts or delights of the U.S.A.! Then are we strange and mysterious creatures who live on self-deception and excitement? We would not last long if that were true. There are too many down-to-earth, routine, everyday realities in Indian hospital life. Then what is it that makes our whole mentality, our outlook on life in India, so totally different from theirs?

Of course, the answer to the whole question lies in one word: vocation. But merely labelling the matter does not explain it. The term vocation has a wide meaning, and is often misunderstood or misapplied. St. Joan of Arc had a vocation from God, so did St. Bernadette. Yet it would be foolish for us to expect such miraculous intervention in our case. Religious vocations abound in the Church like apple blossoms in May. They replace and increase the ranks of priests and sisters, to carry on God's work upon earth. It should be possible to analyze and understand this special call. No matter how personal and individual it may be, basically it is a combination of natural character and supernatural driving forces, yet so powerful that it makes an ordinary American girl choose and stick to a life that would wilt and crumple others.

The first sign of a vocation is an attraction towards the life, a direct, personal interest in it. This is akin to the urge that drives pioneers and explorers away from the beaten path and its comforts, to the thrills and satisfactions of a wider life. Call it a romantic instinct, if you like, a touch of originality, a discontent with the everyday and the ordinary. But in the case of a religious vocation there must be a divine element as well, a higher intention and a deeper reason than the merely human itch for something different. It takes a personal and powerful love of God to carry one over all the obstacles. In a missionary community such as ours this often has an apostolic character—a desire to bring souls to God and God to souls. But it may be simpler and more instinctive than deliberate reasoning, as "God asked me, and I could not bear to disappoint Him. . . ."

Now please do not think that one who has a vocation has to like all of the religious and missionary life at once! A genuine vocation is quite compatible with a black look at black shoes and stockings and a healthy dislike of the 5 a.m. rising bell! Life is definitely not a bowl of cherries. No one likes the thorns on the rosebush, but sensible adults accept them for the sake of the flowers. There is, moreover, no way of telling how many things in the religious life you will like or dislike until you try it. It is quite likely that the things you fear most will end up by being the very ones you like best. There is plenty of time to decide. "Marry in haste and repent at leisure" does not exist in this field.

But the attraction, both human and divine, is not the only factor. With it must go "capability," a combination of physical and psychological qualities that will make a happy and useful religious. In the matter of physical abilities, this offers no difficulties. Obviously, good health and a sound body are needed to stand the busy life. But the mental characteristics are just as important, if not more so. No extraordinary talents are required, no brilliant mind or remarkable powers of will, no exceptional piety. "Suitability" implies a definite combination of qualities which an experienced priest or nun can recognize.

The matter may be simplified by calling it "common sense," which is much rarer than one may think. Sound judgment, steady temper, a

sense of humor, willingness to learn, ability to give and take, interest in others, all are important in the make-up of a medical missionary. Gifts of leadership are valuable, but the ability to follow is also precious. No more than the seeds of the above virtues are required. It is the work of the novice mistress to decide whether or not the right material is present. A normal, sane, balanced person, is no doubt the type God likes best for His work.

Perhaps the commonest fallacy of even many good Catholics in the world it the notion that a religious "buries herself." She gives up everything that makes life interesting and beautiful. From now on she will live in a narrow treadmill of routine drudgery, no freedom, no movies, no shopping, no parties, nothing! Such a viewpoint is simply a caricature of the reality. Of course there are sacrifices to be made. But is there anything worthwhile in this life that does not demand the giving up of lesser goods? But that is only the negative side of the picture. There is also the brighter side.

For the religious life has its own happiness even in this world. God is like that. He compensates, a hundredfold. The choice for those having a vocation lies not between something good and bad, but between something good and better. Even on the natural level there are advantages. Far from cramping and stunting the development of personality, the religious and missionary life actually encourages and induces a wider unfolding, a greater span of interests and range of activities, a broader horizon than falls to the lot of the average housewife. Study, thought, travel, residence in a foreign country, medical work, are hardly stultifying!

And on the supernatural plane, who shall tell of the happiness that comes to those who belong wholly and only to God, who work for Him and with Him and in Him, all the day long and every day, whose every moment, asleep or awake, is spent in doing His Will, without doubt, hesitation or fear of illusion? If you really have a vocation, the "peace that surpasses all understanding" is yours for the taking. Will you take it?

Nursing Over the World

By Sister M. Francis, S.C.M.M.

The recent years of global conflict have focused the attention of the peoples of all nations on the nursing profession. The war nurse has been in great demand and worth her weight in gold. Measures to supply the ever-growing need for nurses for the armed forces and to care for civilian needs have been taken in nearly every country. In our own United States the Bolton Act of 1943 was passed for just this purpose, and the Cadet Nurse in her grey uniform became a familiar sight. The Act provided for the financing of the members of the Cadet Nurse Corps in tuition, other fees and out-door uniforms and provided a monthly allowance of $15 - 30 according to the length of time spent in the Corps. By July of 1945 the United States Public Health Department, Division of Nursing Education, stated that there were more than three thousand Senior Cadets serving in Army hospitals and another 1,178 had been assigned to the Army. The pressure exerted by military need increased the number of graduate nurses from 271,000 in 1940 to 304,344 nurses estimated as available by June 30, 1946.

With the end of armed conflict the question naturally arises, "Will we have a surplus of nurses?" The general consensus of opinion seems to be, "No".

In 1940 no one doubted the need for the expansion of our nursing service. Although residents in the Northeastern States were fairly well supplied with one nurse to 271 of the population, those living in the South, where there was one nurse for every 574 people, certainly could have used more. Rural districts had only one nurse for more than 3,000 residents. Nurses, even more than physicians, were concentrated in the cities.

General civilian needs are greater now than in 1940 because of the increased population. Military, veteran and other federal public health needs are going to require more nurses than they did in pre-war years.

The increased emphasis on health begun during the war will require the services of many more nurses than previously. Openings in hospitals

and other institutions are anticipated to be greater in the post-war world. Increased opportunities are to be found in public health nursing, industrial nursing, and in such specialized fields as tuberculosis, psychiatry, pediatrics, etc. The future opportunity for the nurse depends primarily on the general post-war economy and the demand will necessarily be less than the tremendous war-time need. It is reasonable, however, to believe that the need will be greater than before the war for nursing is an essential factor in all national health programs.

NURSING IN OTHER PARTS OF THE WORLD——LATIN AMERICA

When we come to survey the nursing profession in other parts of the world three things impress us forcibly:

1. The fewness of nurses.
2. The lower standard of training generally prevailing.
3. The lack of respect in which the profession is held.

Across the Rio Grande in the old pre-war days the average senorita would have scoffed at the idea that she become a nurse. Nursing was an occupation on the outer fringe of respectability and nurses were poorly paid and regarded as menials. Nineteen thirty-nine statistics show Mexico, the second largest Latin-American state, to have only 4,500 nurses, the overwhelming majority being of the practical type.

The war has increased that number several times and patriotic Mexican women have hastened to answer the country's need for more and better nurses. The worst enemy to nursing in Mexico has been the Mexican people themselves. With startling nonchalance they accepted the fact that their country had the second highest death rate, that tuberculosis caused the death of 82 out of 100,000, that an Indian child had only a fifty-fifty chance to reach the age of ten, that bubonic plague and other controllable diseases flourished in modern Mexico City.

The threat of war and the vivid demonstration given by wounded survivors of Mexican merchant ships of what war casualties might be, stirred the century-old apathy of the nation and awakened it to an appreciation of the nurses' work. Candidates for nursing swamped the existing facilities and received nursing courses as varied as the applicants. Some received excellent training in top-ranking institutions such as the Army Nursing School or the Nursing School of the National University or in that of the Red Cross in the Mexico City Hospital. Mexico's R.N.'s generally are equal in ability to their sisters across the border but they are pitifully few in number.

In the post-war era Mexico's nurses believe that modern nursing methods will be extended to seventy percent of the Mexicans, patients who are outside the reach of present medical and nursing facilities. The Public Health Department, the Ministry of Public Assistance, the Ministry of Education, to mention a few of the government departments, are absorbing more and more of the available R.N.'s. In Mexico nursing is an up and coming profession.

Argentina, which has the reputation of being the most modern state in South America, still has an inadequate nursing system. In 1943 the rural population of eleven million was served by 1,400 nurses, more than two-thirds of whom had only dubious qualifications. National prejudice against the "working girl" prevents many a young woman from studying nursing, but probably the greatest obstacle is the fact that a nursing career is deemed menacing to morals. Consequently the Argentine nurse is usually "poor in education, pay and prestige".

In general we might say of the South American countries that nursing is still in its infancy as a profession and nursing schools comparable to those in the United States have been in existence less than ten years.

Of late, however, the outlook has changed considerably, especially in view of the program of nursing education being carried on in collaboration with the United States. With eighteen other republics, the United States is cooperating in a well-organized program of health and sanitation. Professional nursing education is being accelerated on a broad scale and through the assistance of United States personnel the training of nurses has been undertaken in sixteen Latin American countries. The aim is to develop nurses' training courses to the point where these republics will be able to carry on nursing education and administration independently. Beyond their professional activities the fifty-three North American nurses working in Latin America personify the Good Neighbor in action.

NEEDS OF THE ORIENT—CHINA

The demand for more nurses is especially voiced in the lands we think of as pagan. Before the war China had 3,000 registered nurses for a population of 450 million. Information available at the end of 1942 revealed that there were in Free China, operating under Christian auspices, 150 hospitals representing eight-five percent of all facilities available in private hospitals here. In about forty of these hospitals nursing schools were still being run, with a total of less than 1,400 student nurses.

Significant are the plans of the Chinese Government for the extension of nursing services. Under the Ten Year Plan the National Health Administration aims to establish 200 schools of nursing, bringing the total up to 276. The number

of graduate nurses needed is 200,000, approximately seventy-five percent of whom will have to come from the new schools.

That this program is not yet in effect is due mainly to limitations of material and personnel. But the plan is there, and the will to carry it out. Let us hope that the courage of the Chinese people in view of the tremendous obstacles they encounter will inspire doctors and nurses of the West to aid them in realizing their aims.

INDIA

For some years now the cry of a shortage of nurses has been raised from every corner of India. The recent years of war have added to this demand the heavy burden of military need, so that greater efforts have at last been made to try to cope with the tremendous health problems which India presents. The proportion of nurses to the population is one trained nurse to over 50,000 of the population. Of 1,000 hospitals in India, less than 140 have trained nurses and over 200 have no nurses at all.

The lack of nurses and the reluctance of Indian women to take up nursing was held by the Director General of the Indian Medical Services (Major General Hance) to be due primarily "to the attitude of the authorities responsible for the maintenance of hospitals and to the conditions in which, too often, probationers are trained and expected to work, than to the alleged reluctance of educated Indian women to undertake the care of the sick. As long as trained nurses are regarded, paid and housed as menials it is not reasonable to expect that large numbers of Indian ladies will come forward to dedicate themselves to this work."

It has been estimated that one million nurses are needed. This of course means that a large group of young people must be attracted to the nursing profession.

In 1943 a school of nursing administration was opened to give trained nurses graduate work. At the time there were only eight sister-tutors in India and the remainder of the teaching of student nurses devolved on the matron of the hospital and the ward sisters.

The new attitude which it is hoped the Indian women will take towards nursing is summarized by Lady Linlithgow . . . "Here is a task which is truly feminine and one which cannot be criticized as being too modern or unwomanly. The nursing profession has from its earliest days demanded self-sacrifice, patience, concentration—attributes which bring out the best in everyone."

While the United States is trying to improve its nursing service, other countries are still struggling to meet the very basic health needs of their people. Medical missionaries, alive and responsive to one of the greatest opportunities now facing the nursing and medical professions, feel that their contribution to the world of tomorrow should be to go where the need is greatest—to promote real friendship and good will, as well as good health. There is a big job ahead—a challenge to the courage, skill and optimism of members of the nursing profession throughout the world.

Nothing proves that one is a faithful lover of Christ like a tender care for one's brothers, and a deep solicitude for their salvation.

—St. John Chrysostom.

Indian Sisters must play an important role in the development of nursing in their native land. Many are trained at Holy Family Hospitals in Patna and Rawalpindi.

The Mission Clipper

FIRST MEDICAL WORK WESTERN HEMISPHERE

The first book on medicine written in the Western Hemisphere and completed in 1552 was the work of a Mexican Indian. A copy of the volume, entitled "Libellus de Medicinalians Indorum Herbis," was discovered in the Vatican Library by Charles Upson Clark, an American scholar, in 1929. The book is profusely illustrated in color and describes the treatment of sickness and disease with Mexican native herbs. The author's prologue reads: "My name is Juan Badiano. I am an Indian, and my country is Xochimilco (near Mexico City). I teach Latin in the College of Santa Cruz of Tialtelolco.

The Pro Martin Institute of the Cross and Juan Badiano Society is organizing a campaign to raise funds for the publication of the work in Spanish and English.

WHITE FATHERS REPORT MISSION PROGRESS

The White Fathers have reported strong gains during the war in Africa, despite an almost complete stoppage of funds and reinforcements. Forty-four new mission stations were opened and the number of African Catholics served by the missionaries increased by 457,242.

Lack of reinforcements is reflected in the fact that many missions have only two priests at present to care for more than 10,000 Catholics and ten times as many unconverted natives spread over thousands of square miles. In Urundi there are ten missions with Catholic populations of between 20,000 and 35,000 supervised by only three or four missionaries.

A number of new recruits were sent out from Britain and Canada to help the overworked missionaries, and newly-ordained African priests also assisted. However, because of the lack of catechists, catechumens under instruction have decreased from 590,000 to 536,000.

On the other hand, while it took fifty years to bring the number of Catholics to one million, the figure was doubled within the last nine years.

The White Fathers now have 27 mission districts in which 251 African priests and more than a thousand Sisters are working.

THE HOLY FATHER'S MISSION INTENTION FOR MARCH: THE MISSIONS WHICH HAVE SUFFERED MOST FROM THE WAR.

MEDICAL MISSION AT MUA

From the Nyasa Vicariate, Africa, the **White Fathers Missions** reports: "The six Sisters at Mua mission have treated 3,345 patients patients in their dispensary and cared for 378 sick in the hospital during the past year. Over 200 babies were born at the Maternity Hospital. In addition, at the Leper Colony, a vilage part with its own chapel and school, there are 162 resident patients and 90 others coming regularly to receive medical care."

FIRST HINDU CAPUCHIN

In 1915 the Bishop of Ajmer, Monsignor Fortunato Caumont, O.F.M. Cap., received a letter from a young man in Bombay, who wrote of his wish to become a Capuchin. Since there was no Capuchin novitiate in India, the Bishop advised the young man to study for the priesthood. After passing the required examination he entered the Papal Seminary at Kandy, Ceylon.

Eight years later a Capuchin novitiate was opened at Sardhana. The seminarian reminded the Bishop of his desire to enter the Capuchin Order. The petition was granted, and he was invested at Sardhana, receiving the name Fidelis, after the illustrious Capuchin apostle, Protomartyr of the Propaganda. When he was ordained by Bishop Caumont five months after his profession, he became the first Hindu Capuchin priest.

—**The Cowl.**

Please pray for the repose of the souls of:

Rev. Mother Manuela Vincente, R.S.C.J.

Sister Mary Lavinia, Baltimore, Md.

Mr. William J. Kavanagh, Conshohocken, Pa.

Mr. John Carey, Philadelphia, Pa. (Father of Sister M. Aloyse, S.C.M.M.)

Mr. Frederick Hangsterfer, Philadelphia, Pa.

Sgt. Charles J. Hicks, Baltimore, Md.

May their souls and the souls of all the faithful departed through the mercy of God rest in peace. Amen.

Be not afraid of going slowly; be only afraid of standing still.

—Chinese Proverb.

"Taklif Kya Hai?"

By Sister M. Leonie Tummers, S.C.MM., M.D.

The above, translated, means "How are you?" Below are some of the answers.

A prominent doctor of medicine once said that were he given the choice between the taking of a history and the examination of the patient, he would choose the history-taking. Since then, I have often wondered whether he would change his mind were he to practice in India.

"Let the patient tell his own story first," is impressed on the budding physician. Here in India one starts out with a cheerful *"Taklif kya hai?"* (What is the matter?) Nine times out of ten the patient will just sit and stare at you—such a strange creature she never saw in all her life! Then, when you repeat the question, adding, "Where is your trouble—in your head, in your stomach, or where," usually one of two answers is forthcoming. Either: "I do not understand English," although you have been using your best Urdu, or "I have a stomach ache." Some of our patients come from the villages scattered around Rawalpindi and the spoken language there is Punjabi, quite different from Urdu. I suppose Urdu spoken with a mixed Dutch-American accent sounds like English to them. Thereupon you try Punjabi, and receive no answer at all or the inevitable stomach ache. In the first case you may try again, phrasing your question differently, hoping it will dawn on the patient that she comes to see the doctor to tell her troubles, or you send for a relative at once if the patient is very young and shy. The stomach ache may turn out to be anything from a senile cataract to advanced tuberculosis, besides the so-frequent amoebiasis. Again, and very often, the patient with a sweet smile will stretch out her arm and say. "Feel my pulse and *you* tell *me* what is wrong with me."

The patients have learned recently to be very much afraid of tuberculosis, and with reason. But instead of helping the doctor with the early detection of the disease, they often mislead her. Perhaps the "cough was only *mamuli*" (ordinary)—but insistent probing will reveal that this ordinary cough has lasted two months or more. It is the same with fever—"We all have fever in the summer time,"

Sister M. Leonie—Taking a Blood Pressure

adding, "Mine was only a very little fever." For those familiar with the signs of early tuberculosis, this is just the characteristic beginning: early fatigue, chronic cough and afternoon elevation of temperature. And fatigue! With the amount of anemia that is prevalent in India, especially among the women, chronic fatigue is as common as is a feeling of well-being at home.

Duration of symptoms is quite a procedure that calls for imagination, knowledge of the different Hindu and Mohammedan feasts and the phase of the moon.

"How long have you had this illness?" might be answered by, "Well, let me see, during the last *roza* (Mohammedan fast) on the third day of the moon I had my first attack," or "Just after *Diwali* (Hindu feast of light)." Occasionally, even our Christmas, *Bara din,* is used.

Arithmetic is not a strong point—you ask a patient:

"How many children do you have?"

"Four, six."

"How many? Four or six?"

"I really have five."

"How many boys and how many girls?" (This, knowing that often girls do not count.)

"Five boys and two girls."
"That makes seven." "Yes."
"Did any of your children die?"
"Yes, two boys died."
"Then you had nine children, seven are living and two boys died, right?"
"Why no, I had four boys, two died and two are living."
"But just a little while ago you told me you had five boys."
"Yes," adding with surprise at our stupidity, "The others are my husband's. I am his second wife."

For many of the poorer patients, coming to the hospital is quite an adventure. They are rather taken aback by what they see and hear, and so frightened at what may happen to them once they are inside the office that they do not know what to say and resort to the polite exclamation, "Ji!"

"Are you ill?" "Ji."
"What is wrong?" "Ji."
"Do you have a headache?" "Ji."
"Is your mother outside?" "Ji."

Finally you have the Punjabi nurse who has been enjoying the situation and is giggling away, ask the questions. Even then you may get the astonishing reply—"I do not understand English," although the nurse is one of the patient's own people and speaks her own language.

To such a patient we talk a little, smile a little and have her come back when she is not so frightened. Once outside she remembers her troubles and proceeds to relate them to the sister, who after a look at the order sheet asks, "Did you tell all that to the doctor?" Then the patient with a shy little smile answers, "I forgot, let me in again and I will tell her."

But it is not always this way. Sometimes a little girl comes in with her baby brother on her hip and gives you in most eloquent fashion, and accurately too, the baby's symptoms. We know one small girl about ten years old who speaks both Pushtu (a dialect spoken in the state of Poonch) and Urdu. She comes and acts as interpreter for the Poonch patients. No difficulties then!

So it goes day in and day out. No wonder patience figures prominently among the virtues necessary for a medical missionary, but it pays to be patient. Many of our clients, after the first fright wears off, are our most faithful attendants and bring any number of relatives and friends. Best of all, they coach these new patients in what they will be asked, and so facilitate this all important "taking of the history."

Dispensary

By Sister M. Alma Julia, S.C.M.M.

"O the oont, O the oont, O the commissariat oont!
With 'is silly neck a-bobbin' like a basketful o' snakes;
We packs 'im like an idol, an' you ought to 'ear 'im grunt,
An' when we gets 'im loaded up 'is blessed girth-rope breaks!"

These words of Kipling's came to my mind as our tonga passed a long row of camels, all piled high with hay or wood and fastened head to tail to each other, each stepping along in his own peculiar stately fashion. It was early morning and we were on our way to the Child Welfare Center and Dispensary. The streets were crowded with all manner of conveyances, animals and pedestrians, for the early mornings are pleasant and cool and soon the strong heat of mid-day would drive all indoors. The sun was just beginning to

"Our most picturesque patient is from the United Provinces . . ."

A story is sometimes the order of the day—in the dispensary. Here Sister Alma Julia holds forth for a group of young listeners.

send out its rays and even the bullocks and buffaloes that usually take up their abode in front of the dispensary had not yet made their appearance. As we stepped from the tonga a group of ragged little children ran towards us, shouting their salaams and giving us their brightest smiles.

As soon as the doors were unlocked and opened the patients seemed to appear from nowhere. Soon we had a noisy houseful all clamoring to be treated at the same time. Little children, all ages and sizes, with infected eyes, infected sores, colds, boils, the ever-present *bukkar* (fever), and other ailments, squatted on their heels around us. Most of the larger children had baby brothers and sisters almost as big as themselves straddled on their hips. Many had to be put under the water tap and given a good scrubbing with soap and water before medicine could be applied.

Suddenly, amid all the babel of babies crying and children chattering, there was a low cry and burkahs were quickly pulled down over the faces of the women who were sitting in the courtyard waiting to be seen. A man had appeared in the doorway carrying his sick child!

One woman brought her three children. The little girl, about eight years old, had had fever for three days; a little boy of five had very badly infected eyes, and the baby was covered from head to toes with mosquito bites. After all three had been treated and the little one painted well with crystal violet, the boy of five, who was shedding copious tears, turned to his mother and started to beat her with his little fists for subjecting him to such treatment! The mother took the beating good naturedly and it was an amusing scene, for her own two hands were occupied in holding the baby in an upright position until all the crystal violet dried.

The majority of the children come each day to get their dose of cod-liver oil emulsion. It would be useless to give them a quantity to take at home for they would never take it. So too, the children with infected eyes come daily for irrigations and drops. It is really pitiful to see the number of babies, children and even adults with eyes swollen and full of puss, just from carelessness and lack of cleanliness.

One of our most picturesque patients is a woman from the United Provinces. Her dress is very different from that of the Punjabi women. She wears a yellow, long-sleeved blouse, very finely pin-tucked by hand, and a bright orange skirt about five yards in width which falls in folds to her ankles. A bright red piece of material used as a shawl is draped gracefully over her head. Twelve or fifteen bracelets adorn her arms and another five or more on each ankle make tinkling music as she walks. She also has rings on both fingers and toes. It took a long time for this woman and her family to be friendly but now they come freely of themselves for any slight ailment. One day we took her picture—and a little Sikh boy who happened to see Sister doing so, demanded that his picture be taken too. Perhaps it was because he was wearing a brand new blue pugri!

News from Home and Abroad

AT HOME

PROFESSION AND RECEPTION

February 11, the Feast of Our Lady of Lourdes, brought Profession and Reception Day once more

Sister M. Adelaide

when three novices made their first vows as members of the Society and eight postulants received the religious habit. The ceremony which was held in the Motherhouse Chapel came as the climax of an eight-day retreat conducted by the Rev. John Anderson, O.S.A. of Villanova, Pa. The Rt. Rev.

Sister M. Boniface

Msgr. Thomas F. McNally of Jenkintown, Pa. presided, assisted by the Rev. Charles J. Mahoney, C.S.C. Present also were the Rev. James A. Magee of Philadelphia, the Rev. Joseph A. Dougherty, S.J. of Baltimore, Md., and the Rev. Vincent Luther of Renovo, Pa.

The three novices who pronounced their first vows were: Sister Mary John (Helen Zweber) of Hastings, Minn; Sister M. Adelaide (Monica Orem) of Baltimore, Md., and Sister M. Boniface (Marie Lischwe) of Brinktown, Mo.

The following postulants received the grey habit of the Society: Miss Rita Kroska, R.N. of Faribault, Minn., in religion, Sister M. Judith; Louise DuBrul, M.D., of Cincinnati, Ohio, Sister M. Marcella; Miss

Sister Mary John

Jane Gates of Hamburg, N. Y., Sister Mary Gregory; Miss Ruth Petonyak of Renovo, Pa., Sister M. Carmel; Miss Joan Jollett of Patterson, N. J., Sister M. Gabriel; Miss Margaret Mary Reese of Philadelphia, Pa., Sister M. Edward; Miss Joan Spaeth of Cincinnati, Ohio, Sister M. Theodore, and Miss Phyllis Salz of Dubuque, Iowa, Sister M. Charles.

INDIA

RAWALPINDI

News from India includes a bit of everything this month—a nurses' convention, buses, babies. . . .

From Rawalpindi Sister M. Dolores writes of the convention she attended in Delhi. . . . "I have just returned from Delhi where the Nurses' Meeting was held this year. In connection with the meeting a recruitment program was held with the purpose of making girls interested in nursing. Demonstrations were staged by student nurses. Two of our sister-students went with me and demonstrated bathing a baby. Sister Laetitia also had two students from Patna there who demonstrated setting up for an emergency operation. The Patna students sent an exhibit of a miniature nursery. It was lovely and won second prize."

American Uniform!

"The two little sister-students with me wear a habit which resembles the sari of their native province. Around their necks they wear beads with a crucifix attached. Naturally their odd but pretty habits evoked much comment. I

was walking with them one day at the meeting when two school girls passed us. One remarked to the other—"Those two are from an American hospital. That's the American uniform!' "

Rawalpindi Refrain . . .

Sister M. Leonie takes up the news from Rawalpindi with the refrain—"The hospital is still overflowing. We have over a hundred more delivery cases this year than last year. People in the out-patient department are even asking to have the room number put on their tickets so they will be sure to get a room. Oh for a large hospital with plenty of beds! Our out-patient department too, is on the increase. Last Monday we had close to three hundred patients.

G. I. Generosity

Over and over again our Sisters have benefited by the generosity of the American soldiers in India. Sister Leonie continues . . . "Last week Sister Alma went to Delhi and visited the American hospital there. She met the chaplain and it seems the whole American Army. Anyway, she came home with a trunkful of things, including a washboard (an unknown luxury in these parts), some P & G Soap, Kleenex, chewing gum and a pack of cards. The last were very welcome as our own were worn out. Yes, we still indulge in bridge during recreation."

Pioneering Via Buses

Apparently Sister Alma Julia is a prime traveler, for Sister Leonie says of her—"I imagine Sister Alma Julia has told you all about the new buses we have here. She is our pioneer on them and knows exactly where they come from and where they go. The conductors are very courteous in helping her in and out and make sure she takes the seat in the lady's part of the bus right behind the driver. The new buses are nice looking conveyances—yellow with brown bands. And they are ever so much cheaper than the tongas. The poor tonga-wallahs will feel it in their trade."

Learn The Language

Here's a story Sister Alma Julia tells of Sister Leonie . . . "Not long ago Sister Leonie told one of our dispensary patients about some quadruplets born recently in the United States. Now Sister thinks her Urdu is pretty good—but perhaps this lady was a Punjabi and did not know Urdu so well. Anyway, she did not get the story straight, or else the 'story grew', as those things do. The next thing we knew it was all over Rawalpindi that we had quadruplets born in Holy Family Hospital. Perhaps worse things than that go the rounds due to not knowing the language too well. The moral is to learn the language!"

MARY GIRI

Snake-Time!

Sister M. Pauline keeps supplying us with snake stories. The latest is that it's "snake time" down in Mary Giri. She writes . . .

"We are having the 'little monsoon' at present, so practically every day we have a thunder storm. If a day passes without a storm we feel as if the whole world is resting on our heads. It is also the time for snakes; they come out after the rain. Last week a coolie walking at the end of our compound was bitten by a cobra. His condition was critical for a few days, but now he will recover. Sister Veronica saw a huge snake when she went to ring the angelus bell. It is so big and often hides among the pineapple plants."

Recipe For Keeping Warm

Sister Pauline enclosed some Indian recipes in her last letter. . . . Here's one that will help to keep the chill of March winds away . . . She writes . . . "I do believe it might save on oil or coal if you ate some nice hot chutneys or curries on winter days. They make one feel as though a fire had been lit inside. I remember that we used to have 'curry' occasionally, but what was missing to make it really hot was the 'chili'." This is very hot and makes a good curry or chutney."

Sister also enclosed a recipe for a "tasty chutney." Here it is, in case you would like to try it too. . .

Recipe for Chutney

10 dry chillies—red
One handful of garlic
One handful of raisins
½ teaspoon ginger
One cup sugar
About a pint of vinegar
¼ teaspoon mustard

Put all ingredients except the sugar into the vinegar for five minutes. Then put all together through a fine meat grinder. (Here we grind them with stones.) Pour the vinegar into a frying pan with the sugar. When the sugar is dissolved, add the prepared ingredients, mix and when well heated remove from the fire. Serve cold with meat.

We're going to try it. Are you?

The health and well being of our neighbor at home and in distant parts of the world can longer be ignored. Medical work must play an important role in Catholic mission work of the future. Mother Anna Dengel, M.D., Foundress and Superior General of the Medical Mission Sisters, has dawn upon her many years of experience and knowledge of medical missions to give a survey of the field in --

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The Missioner

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—Rev. John J. Considine, M.M.